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	155368	A. BUILDING 00 B. WING	04/29/2011

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TODD DICKEY NURSING AND REHABILITATION CENTER	712 WEST 2ND STREET LEAVENWORTH, IN47137

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: April 25, 26, 27, 28, & 29, 2011 Facility number: 000490 Provider number: 155368 AIM number: 100291320 Survey team: Terri Walters RN TC Carole McDaniel RN Martha Saull RN Dorothy Navetta RN Elizabeth Harper RN Census bed type: SNF/NF: 59 Total: 59 Census payor type: Medicare: 18 Medicaid: 37 Other: 4 Total: 59 Sample: 15 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on May 4, 2011 by Bev Faulkner, RN			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A. Based on observation. record review and interview, the facility failed to manage the hollering behavior of Resident #45 and identify the negative impact the behavior had on the resident's two roommates Resident #44 and Resident #46. These deficient practices affected 1 of 1 reviewed with the behavior of hollering and 2 of 2 residents impacted by the behavior. Resident #45 Resident #44 Resident #46 B. Based on observation, interview, and record review, the facility failed to identify, track, and monitor behaviors for 2 of 3 residents reviewed for behaviors in a sample of 15. Resident #45, Resident #54 Findings include: A.1. During initial tour of the facility on 4/25/11 at 9:00 A.M., Resident #44 was observed in her room with her roommates,	F0250	It is the policy of Todd-Dickey Nursing and Rehabilitation Center to ensure that medically related social services are provided to attain or maintain the highest practicable physical, mental abd psychosocial well-being of each resident.1. A. Resident #45 was moved to a different room with no roommates at this time, until a more suitable roommate is found. B. Residents #45 and #54 have been placed on every shift charting and behaviors/mood is noted for both in Care Tracker for further assessment. 2. A one time encompassing clinical review including, but not limited to, the past 30 days of nurses notes, social services notes, Behavior Monitoring report, 24 Hour Status report, physicians orders and roommate and staff interviews on current in-house residents will be completed to identify aggressive or disruptive behaviors/issues and be performed by IDT members. Any resident identified through record review or staff interview will be re-assessed with	05/29/2011

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	Resident # 45 and Resident # 46. Upon arrival at the room, Resident #45 was hollering out loud. It was unknown when the hollering had begun. Resident #44 stated "I didn't sleep all night. I need a new room. My neighbor hollers too much." Resident # 45 hollered out loud from at least 9:00 A.M. until 9:11 A.M., and could be heard in the hall five rooms away. Staff responded to the hollering twice in that time frame by hollering over the hollering of Resident #45 while trying to determine if Resident #45 wanted her TV channel changed. Each time the hollering subsided was for less than one minute. It was noted, at that time, that the head of the bed of Resident #45 was positioned at a right angle to the head of the bed of Resident # 44 and separated approximately 2 foot. There was a privacy curtain hanging in the 2 foot space. Although each resident was in their own chair at the time, the bed positions with heads together were relevant at times when the residents were abed and during the night. On 4/25/11 at 10:15 A.M., the clinical record of Resident #44 was reviewed. Diagnoses included but were not limited to Lupus, legally blind and depression. The Minimum Data Set Assessment		plan of care revision and/or update as needed by the SSD and reviewed by the IDT to ensure the plan of care includes appropriate prevention interventions based on assessment.3. SSD will be re-educated to facility Behavior Management Program policy including, but not limited to preventive interventions for loud and/or aggressive behavior. SSD will perform a weekly random audit of five residents with roommates, including interviewing staff members, to ensure there are no issues. SSD will also perform a weekly audit of five resident charts, including Care Tracker reports, for any new changes in mood or behavior.Staff members will be re-educated to document behaviors in chart, Care Tracker, and/or with charge nurse as well as reporting any roommate issues/complaints to charge nurse or nursing supervisor, for further investigation by SSD. Identified residents will be taken to the next scheduled DCR and reviewed by the IDT to determine possible causes of behaviors as well as appropriate interventions. The clinical record including plan of care will be updated to reflect current status of resident.4. The QA committee will review the results of these audits on a monthly basis for any change or updates, as indicated. Any non-compliance will be addressed	

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	(MDS) of 3/24/11 indicated the resident had intact cognition. The Care Plan of 3/18/11 indicated "Resident is interviewable." The Social service progress notes on 3/18/11 included a notation under the criteria of "Target Mood." The notation was "trouble sleeping- feeling tired..." Documentation was lacking of assessment of sleep problems or potential etiology. On 4/25/11 from 11:45 A.M. until 12:05 P.M., Resident #45 hollered out loud with intervals of rest no longer than 2 minutes. The hollering could be heard at the nurses' station on the opposite end of the length of the hall, 75 feet from the resident's room. By observation on 4/25/11 from 4:45 P.M. until 5:05 P.M., Resident #45 was in her room with her roommates (Resident #44 and #46) while she intermittently hollered. The hollering was audible at the nurses' desk where 2-3 nurses were present throughout the time and 2 CNAs were present in the hall getting residents up for supper; however, no staff responded to the hollering. The Social Services Director (SSD) was interviewed on 4/27/11 at 10:20 A.M., regarding the impact of Resident # 45 on Resident #44. The SSD stated "When I		by the administrator/DON through 1:1 re-education and/or disciplinary action.	

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	go to visit (name of Resident #44) she never says any problems and (name of Resident #45 is usually quiet when I visit). The SSD also stated "(name of Resident #46 who was the 3rd resident housed in that room) says when (name of Resident #45) starts hollering she gets up and goes over and talks to her and she quiets right down." She indicated she had not identified there was a problem to be assessed. On 4/27/11 at 1:30 P.M., a confidential visitor interview indicated in the area of Resident #45 there are "... a few people that cry all the time...cry a lot, yells and yells..." Room occupation logs reviewed on 4/28/11 at 11:30 A.M., indicated Resident # 44 and Resident #45 had been housed in the same room together since 11/24/10. On 4/27/11 at 1:40 P.M., the SSD indicated after she was informed of the problem, she had a plan to diminish the impact of the hollering by changing room placements. Resident #46 was very happy to be moving in with another resident down the hall since they had common history and could visit with each other. Resident #45 was being transferred with family consent to a room by herself nearer the nurse's station, which the			

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	family had wanted. Resident #44 was going to be alone, at least temporarily and would have quiet. On 4/28/11 at 10:00 A.M., Resident #44 indicated she was enjoying the quiet and had slept well last night. B.1. Resident #45's clinical record was reviewed on 4/25/ 11 at 2:50 P.M. Her current Minimum Data Set Assessment (MDS), dated 4/22/11, indicated a moderate cognitive impairment. No physical or verbal behaviors directed toward others had occurred. Other behaviors not directed toward others (behaviors such as hitting or scratching self) had occurred in 1 to 3 days. Medications received during the last 7 days included an antidepressant, antianxiety and an antipsychotic medication. Diagnoses included but were not limited to: profound mental retardation and seizure disorder. Resident #45's current care plan (initiation date 2/12/11) addressed the problem of behavioral symptoms with the behavior "verbal/local symptoms i.e., screaming, disruptive sounds) selected." Goals included, no injury to self or others, accepting care, and reducing the frequency of behavioral symptoms.			

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	Interventions included but were not limited to: treat medical condition, approach calmly and smile and call resident by her name, and "monitor/document behaviors -notify MD& or Psych.(psychiatric care services) as needed." A mood and behavior symptom care plan dated 2/12/11, addressed the problem of "yells out." The goal was to reduce or eliminate unhappy behavior symptoms." Interventions included but were not limited to: psychiatric care services, assess for pain, provide headphones with music, and "monitor /document any changes in mood-refer to MD or psych. (psychiatric care services) as needed." On 4/25/11 at 9:00 A.M., during initial tour of the facility, Resident #45 was heard from her room yelling out. Her two roommates were also present in the room at this time. The yelling behavior continued until 9:11 A.M. On 4/25/11 at 11:45 A.M., Resident #45 was heard yelling at intervals from her room which could be heard at the nurses' station (75 feet from resident room to nurses station) until 12:05 P.M. On 4/25/11 at 4:30 P.M., during evening observation, Resident #45 was heard at the nurses' station yelling from her room			

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	(a distance of 75 feet). On 4/25/11 at 4:50 P.M., Resident #45 was still heard yelling from her room. On 4/25/11 at 4:45 P.M., Resident #45 was yelling from her room and could be heard at the nurses' station,a distance of 75 feet. On 4/25/11 at 5:03 P.M., Resident #45 continued to yell at intervals. On 4/26/11 at 10:00 A.M., care was provided by CNA #1 and CNA #2. Resident #45 was turned and repositioned, provided incontinence care, and transferred per hoyer lift out of bed . Resident #45 was observed during this care at intervals to pinch and hold on to both CNAs and bite at her own fingers. On 4/26/11 at 12:05 P.M., LPN #1 provided feeding tube feeding and dressing change. Resident #45 was observed to grab LPN #1's arm and not let go and spit at intervals. On 4/28/11 at 10:05 A.M., the Social Service Director (SSD) was interviewed regarding the behaviors of Resident #45 and Resident #45's computerized behavior logs. She indicated the targeted behaviors for Resident #45 were "spitting" and "yelling " behaviors. At			

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	this time the behavior logs of Resident #45 from 3/1/11 thru 4/26/11 at 12:12 P.M., were reviewed. Documentation was lacking of any behaviors occurring through out this time period. The SSD at this time was made aware of yelling behavior, spitting behavior, pinching and holding on to staff, and the resident biting at her fingers during observations of care on 4/25/11 and 4/26/11. She indicated at this time she was unaware of the Resident #45 exhibiting behaviors of pinching and grabbing of staff or of the resident biting at her fingers. She indicated she would add these behaviors to Resident #45's care plan. On 4/28/11 at 11:05 A.M., CNA#1 was interviewed regarding care of Resident #45 on 4/26/11 at 10:00 A.M. She indicated the behavior of pitching, spitting and the resident biting her fingers were not new behaviors. B.2. The clinical record of Resident #54 was reviewed on 4/25/11 at 10:10 A.M. Diagnoses included, but were not limited to, the following: Impulse control disorder, intermittent explosive disorder and profound mental retardation with psychotic features. A hospital progress note, dated 3/18/11, indicated the following: "The patient is a			

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	51 year old female who presents with a complaint of altered mental status. The altered mental status has been occurring in a persistent pattern for years. The course has been increasing. Nurses report that the patient was born at 6 months gestation with cerebral palsy and lived with her family until 1975. After that time patient was at (state mental hospital) for a number of years and then from there patient was in a group home...Patient's behavior continued to decline with aggressiveness and explosiveness and was recently admitted to the behavior unit at (hospital name) on 3/2/11. Since the patient has returned to (nursing home name) the nurses report that the patient's behavior has continued to worsen, she has been aggressive with the staff touching herself inappropriately, raising her shirt, throwing things and screaming out." A physician order, dated 2/9/11, indicated the resident was receiving Jevity bolus feedings G-tube (gastronomy tube). Nurse notes, dated 2/14/11 at 12 P.M., indicated the following: "Resident propelled self into DR (dining room). Took a lg (large) bite out of another resident sandwich before staff could intervene, swallowed it without difficulty, was upset when removed from DR."			

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	Documentation for the 24 hour resident flow record indicated 15 minute checks were begun on the resident on 2/16/11 at 12:15 P.M. These 15 minutes check continued until 3/2/11 at 3:30 P.M., when the resident was placed on 1:1 supervision. Nurses notes, dated 2/16/11 at 1:30 P.M., indicated the following: "Resident propelled self into DR. Consumed food off another resident's tray..." Documentation on the 15 minutes check report (24 hour resident flow record) indicated the resident was in the hall at 1:30 P.M., on 2/16/11. Documentation on the Behavior Detailed Entry Report was lacking for 2/16/11. Nurses notes, dated 2/17/11 at 10:20 A.M., indicated the following: "Resident grabbed cup off of fluid cart and took a drink when staff was passing out drinks. No choking or aspiration noted." Nurses notes, dated 2/20/11, indicated the following at 3:40 P.M.: "Res (resident) came behind nurses desk et (and) got into CNAs (certified nursing assistant) purse et ate an (sic) cigarette...Dr. (physician name) aware. To monitor res for n/v (nausea/vomiting). Per Dr. (physician			

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	name) check VS (vital signs) every shift for 72 hours..." Nurses notes, dated 2/21/11 at 3 A.M., "...no adverse reactions to eating a cigarette..." A hospital note, dated 3/2/11, indicated the following: "With G-tube feedings, will reevaluate her dysphagia and get a swallow study to see if she can start eating..." A physician order, dated 3/11/11, indicated the following: "order to change diet to dysphagia III with thin liquids, administer with a sippy cup." The February Behavior Detail Report was received from the SSD on 4/28/11 at 11 A.M. This report indicated for the date 2/20/11 the resident did not have any of the behaviors, which included but were not limited to, the following: verbally abusive, physically abusive, socially inappropriate and resist care. Nurses notes, dated 2/24/11 at 9 A.M., indicated the following: "...pleasant during that time, she was sitting near the nurses station, all of a sudden she throw (sic) her shoe across the desk; she then propels her w/c (wheelchair) to the gate at the desk; began slamming (sic) it against the wall; spun her w/c in circles, staff unable to redirect her outburst of			

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	behavior; she then began biting herself; pulling her hair, attempted to tip w/c backwards, kicking at the wall; when staff spoke to her, she will just smile. Documentation on the behavior Detailed Entry Report was lacking for 2/24/11. Nurses notes, dated 2/28/11 at 8 P.M., indicated the following: "Rsd (resident) increased agitation - throwing baby doll and shoes in hallway. Screaming out. This nurse attempted to calm rsd and rsd grabbed and broke my necklace...pulled her hair as well as bite herself on her l (left) wrist area." Documentation on the behavior detailed entry report was lacking for 2/28/11. An Accident/Incident Report, dated 3/1/11 at 6:30 P.M., indicated the following: "Res (resident) hit (another resident number) in rt (right) upper arm." The immediate action taken to prevent further incidents was listed as "Res removed from E. (east) DR (dining room), cont (continue) on 15 min (minute) checks." The March 2011 Behavior Detail Report, dated 3/1/11, lacked documentation of the resident being physically abusive. A facility incident report form addendum,			

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	dated 3/3/11 and referencing the 3/1/11 incident, included, but was not limited to, the following: "While resident (#54) was on increased supervision and sitting in the hallway, resident grabbed the arm of a passing resident and proceeded to bite the resident's right wrist before staff could intervene. Caused bruise...no break in skin noted..Res (#54) placed on one on one supervision..." On 4/27/11 at 9:30 A.M., the DON (Director of Nursing) and SSD (Social Service Director) were interviewed. They indicated when a resident has a behavior, the staff enters the behavior into the care tracker (facility computer system for documentation). They indicated the care tracker shows which behaviors the resident has been having by category so the CNAs (certified nursing assistants) will know if the resident is having a new behavior or not. The SSD indicated that she prints off the behavior tracking log daily to review to see if they see a pattern. She indicated if the behavior was unusual, they would look into it. She indicated they use the "Behavior Detailed Entry Report" at meetings to discuss behaviors. The DON indicated other tools are used in the behavior meetings including but not limited to, 24 hour reports and physician orders.			

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	On 4/27/11 at 9:20 A.M., the DON provided a copy of the policy and procedure "Target Behavior/Target Mood Occurrence." This policy was dated October 2009. This policy included, but was not limited to, the following procedure: "Communicated target behavior using the Care Tracker resident centered program for target behavior/target mood and the appropriate plan of care...The nursing assistant will: Document using Care tracker with each occurrence of the target behavior/target mood; report target behavior to the charge nurse; all other disciplines will report behaviors and communicate to the nurse via care tracker; record occurrences of target behavior/target mood symptoms; note ineffective interventions for a target behavior using care tracker mood and behavior section; If new interventions are tried and effective, report interventions to the nurse for addition to the appropriate plan of care and care delivery guide; address ineffective behavior interventions at the next daily clinical review meeting;...discuss target behaviors with the nursing assistants and determine effectiveness of current interventions and medications...plan to further assess or treat as needed...update interventions and target behavior/mood as deemed necessary per resident in care tracker resident centered program.			

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	155368	A. BUILDING 00 B. WING	04/29/2011

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	On 4/28/11 at 10:15 A.M., the DON (Director of Nursing) provided a current copy of the facility policy and procedure titled "Resident Supervision." This policy was dated January 2009. This policy included, but was not limited to, the following: "(name of facility) strive to provide the appropriate level of supervision, ensure an immediate and optimal level of safety and outcome for the resident. The center will continually evaluate the level of supervision needed through assessment and observation of the resident's cognitive, behavioral, medical or other conditions that put them at risk to self or others...Procedure:...initiate "increased supervision" upon identification of a resident exhibiting behaviors that present significant risk...3. Notify the following as soon as possible to determine if increased supervision is required:.../charge nurse, DON, Nursing Supervisor...consult the...DON and attending physician/provider to determine the level of supervision necessary and/or possible treatment alternatives...Review "Increased, Close Visual and Resident Specific" supervision levels Monday through Friday during the appropriate daily clinical meeting. The IDT (Interdisciplinary Team) will determine when the level of supervision will change..."			

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	On 4/28/11 at 10:30 A.M., the policy and procedure for "Resident Supervision" was received from the ADON (Assistant Director of Nursing). This policy was most recently updated January 2009. This policy included, but was not limited to, the following: "Increased Supervision: This category is for residents that will have a staff member assigned to do a visual check on the resident every 15 minutes. The assigned staff member is responsible to observe and supervise the resident when conducting the check to ensure that the resident is safe and remains in a designated area. Observations will be documented every 15 minutes using the 24 hour resident flow record. "Increased" level of supervision is often used as a means of gradually withdrawing the resident from a higher level of supervision. On 4/28/11 at 10:50 A.M., the SSD (Social Service Director) was interviewed. She indicated the resident was on "general supervision" before the incident on 2/16/11, when she took food from another resident. The SSD indicated at that time, on 2/16/11, the resident was placed on increased supervision/15 minutes checks. She indicated the resident had a wanderpole (tall pole attached to the wheelchair) to prevent the resident from			

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	entering other resident rooms. The SSD indicated the resident was placed on 1:1 supervision from the time she bit another resident on 3/2/11 at 3:30 P.M., until she was transferred to the behavior unit on 3/2/11 at 5 P.M. The SSD indicated when residents have behaviors that endangers another resident (for example biting), the residents would be re evaluated to see if there needs to be a change in their supervision status. She indicated this would have been reviewed/discussed at the IPOC (Interdisciplinary Plan of Care) meetings. After review of the clinical record, she indicated documentation was lacking of this review. She indicated documentation was lacking in the clinical record of a reassessment of the resident's supervision status/needs. The SSD was made aware at this time, the resident's clinical notes and the Behavior Detailed Entry Report did not reflect the same information regarding the resident's behaviors. The clinical record had more documented incidents of behaviors, that were to have been tracked on the Behavior Detailed Entry Report, and documentation of these behavior incidents were lacking on the Behavior Detailed Entry Report. On 4/28/11 at 1:16 P.M., the DON was interviewed. She indicated "close visual supervision" would be considered 1:1			

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	supervision, as defined in the policy and procedure for Resident Supervision. She was made aware of the discrepancy of behaviors documented in the clinical record versus the lack of those documented on the Behavior Detail Report. She indicated staff utilize various tools to review behaviors at the DCR (daily clinical review) meetings including, but not limited to, nurses notes, physician orders and 24 hour report. She indicated the intervention put in to place after the resident ate the cigarette on 2/20/11 was she was placed on 72 hour charting. She indicated 72 hour charting indicates the nurses monitored her vital signs and monitored her for nausea and vomiting. The DON indicated the resident has continued on 1:1 supervision since her return to the facility on 3/11/11. The SSD (social service director) joined the interview at 1:20 P.M. She indicated she was unable to find documentation of the resident in her documentation and/or the IDT/DCR notes regarding the resident ingesting a cigarette on 2/20/11. 3.1-34(a)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on interview and record review, the facility failed to ensure adequate supervision to prevent behavior interactions between a resident with known behaviors (Resident #54) and another resident (#46) reviewed for behaviors in a sample of 15. Resident #54, Resident #46 B. Based on interview and record review, the facility failed to ensure adequate supervision to prevent falls for 1 of 3 residents reviewed for falls in a sample of 15. Resident #100 Findings include: A. The clinical record of Resident #54 was reviewed on 4/25/11 at 10:10 A.M. Diagnoses included, but were not limited to, the following: impulse control disorder, intermittent explosive disorder and profound mental retardation with	F0323	It is the policy of Todd-Dickey Nursing and Rehabilitation Center to ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.1. A. Resident #54 remains on 1:1 supervision for behaviors. Resident #46 is on every shift charting for mood and behaviors.B. Resident #100 has expired.2. A one time clinical review including but not limited to, past 30 days of nursing notes, social services notes, Behavior Monitoring report, 24 Hour Status report and physicians orders as well as staff interviews, will be conducted by the IDT, on current in-house residents, to review behaviors and need for further interventions/supervision, as well as on residents at risk for falls.Any resident identified through record review or staff interview will be re-assessed with plan of care revision and/or update as needed by the IDT to	05/29/2011

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	psychotic features. A physician order, dated 2/9/11, indicated the resident was receiving Jevity bolus feedings G-tube (gastronomy tube). Nurse notes, dated 2/14/11 at 12 P.M. indicated the following: "Resident propelled self into DR (dining room). Took a lg (large) bite out of another resident sandwich before staff could intervene, swallowed it without difficulty, was upset when removed from DR." Documentation for the 24 hour resident flow record indicated 15 minute checks were begun on the resident on 2/16/11 at 12:15 P.M. These 15 minutes check continued until 3/2/11 at 3:30 P.M., when the resident was placed on 1:1 supervision. Nurses notes, dated 2/16/11 at 1:30 P.M., indicated the following: "Resident propelled self into DR. Consumed food off another resident's tray..." Nurses notes, dated 2/17/11 at 10:20 A.M., indicated the following: "Resident grabbed cup off of fluid cart and took a drink when staff was passing out drinks. No choking or aspiration noted." Nurses notes, dated 2/20/11, indicated the		ensure the plan of care includes appropriate preventative behavior management and fall prevention interventions based on assessment.3. Staff members will be re-educated to ensure that residents with behaviors are monitored and the charge nurse/nurse supervisor are notified of increase in behaviors and if resident is a threat to self or others. The DON/designee will audit five resident charts weekly, at random, for increase in behaviors and need for increased supervision.Staff members will also be re-educated on fall prevention/supervision of residents, including residents with alarms, who are not to be left on toilet unsupervised. The DON/designee will audit five resident charts weekly, at random, to identify residents at risk for falls and fall prevention measures. The DON/designee will also perform five care observations, at random, for residents with falls.Identified residents with behaviors or falls will be taken to the next scheduled DCR and reviewed by the IDT to determine possible causes of behavior as well as appropriate behavioral interventions and to ensure current fall prevention interventions remain appropriate with the residents current status. The clinical record will be updated to reflect resident change of status. Behavioral Management	

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	following at 3:40 P.M.: "Res (resident) came behind nurses desk et (and) got into CNAs (certified nursing assistant) purse et ate an (sic) cigarette...Dr. (physician name) aware. To monitor res for n/v (nausea/vomiting). Per Dr. (physician name) check VS (vital signs) every shift for 72 hours..." Nurses notes dated 2/21/11 at 3 A.M. "...no adverse reactions to eating a cigarette..." Nurses notes, dated 2/24/11 at 9 A.M., indicated the following: "...pleasant during that time, she was sitting near the nurses station, all of a sudden she throw (sic) her shoe across the desk; she then propels her w/c (wheelchair) to the gate at the desk; began slamming (sic) it against the wall; spun her w/c in circles, staff unable to redirect her outburst of behavior; she then began biting herself; pulling her hair, attempted to tip w/c backwards, kicking at the wall; when staff spoke to her, she will just smile." Nurses notes, dated 2/28/11 at 8 P.M., indicated the following: "Rsd (resident) increased agitation - throwing baby doll and shoes in hallway. Screaming out. This nurse attempted to calm rsd and rsd grabbed and broke my necklace...pulled her hair as well as bite herself on her l (left) wrist area."		System Review and Falls audits are in place and will be completed by the IDT on a monthly basis to ensure continued compliance with the Risk Reduction and Behavioral Management programs.4. The QA committee will review the results of these audits on a monthly basis and up-date as need indicates. Any non-compliance will be addressed by the administrator/DON through 1:1 re-education and/or diciplinary action.	

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	An Accident/Incident Report, dated 3/1/11 at 6:30 P.M., indicated the following: "Res (resident) hit (another resident number) in rt (right) upper arm." The immediate action taken to prevent further incidents was listed as "Res removed from E. (east) DR (dining room), cont (continue) on 15 min (minute) checks." A facility incident report form addendum, dated 3/3/11 and referencing the 3/1/11 incident, included, but was not limited to, the following: "While resident (#54) was on increased supervision and sitting in the hallway, resident grabbed the arm of a passing resident and proceeded to bite the resident's right wrist before staff could intervene. Caused bruise...no break in skin noted..Res (#54) placed on one on one supervision...." A hospital note, dated 3/2/11, indicated the following: "With G-tube feedings, will reevaluate her dysphagia and get a swallow study to see if she can start eating..." A physician order, dated 3/11/11, indicated the following: "order to change diet to dysphagia III with thin liquids, administer with a sippy cup." A hospital progress note, dated 3/18/11, indicated the following: "The patient is a			

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	51 year old female who presents with a complaint of altered mental status. The altered mental status has been occurring in a persistent pattern for years. The course has been increasing. Nurses report that the patient was born at at 6 months gestation with cerebral palsy and lived with her family until 1975. After that time patient was at (state mental hospital) for a number of years and then from there patient was in a group home...Patient's behavior to decline with aggressiveness and explosiveness and was recently admitted to the behavior unit at (hospital name) on 3/2/11. Since the patient has returned to (nursing home name) the nurses report that the patient's behavior has continued to worsen, she has been aggressive with the staff, touching herself inappropriately, raising her shirt, throwing things and screaming out." On 4/28/11 at 10:15 A.M., the DON (Director of Nursing) provided a current copy of the facility policy and procedure titled "Resident Supervision." This policy was dated January 2009. This policy included, but was not limited to, the following: "(name of facility) strive to provide the appropriate level of supervision, ensure an immediate and optimal level of safety and outcome for the resident. The center will continually evaluate the level of supervision needed			

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	through assessment and observation of the resident's cognitive, behavioral, medical or other conditions that put them at risk to self or others...Procedure:...initiate "increased supervision" upon identification of a resident exhibiting behaviors that present significant risk...3. Notify the following as soon as possible to determine if increased supervision is required:.../charge nurse, DON, Nursing Supervisor...consult the...DON and attending physician/provider to determine the level of supervision necessary and/or possible treatment alternatives...Review "Increased, Close Visual and Resident Specific" supervision levels Monday through Friday during the appropriate daily clinical meeting. The IDT (Interdisciplinary Team) will determine when the level of supervision will change..." On 4/28/11 at 10:30 A.M., the policy and procedure for "Resident Supervision" was received from the ADON (Assistant Director of Nursing). This policy was most recently updated January 2009. This policy included, but was not limited to, the following: "Increased Supervision: This category is for residents that will have a staff member assigned to do a visual check on the resident every 15 minutes. The assigned staff member is responsible to observe and supervise the			

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	resident when conducting the check to ensure that the resident is safe and remains in a designated area. Observations will be documented every 15 minutes using the 24 hour resident flow record. "Increased" level of supervision is often used as a means of gradually withdrawing the resident from a higher level of supervision." On 4/28/11 at 10:50 A.M. the SSD (Social Service Director) was interviewed. She indicated the resident was on "general supervision" before the incident on 2/16/11 when she took food from another resident. The SSD indicated at that time, on 2/16/11, the resident was placed on increased supervision/15 minutes checks. She indicated the resident had a wanderpole (tall pole attached to the wheelchair) to prevent the resident from entering other resident rooms. The SSD indicated the resident was placed on 1:1 supervision from the time she bit another resident on 3/2/11 at 3:30 P.M., until she was transferred to the behavior unit on 3/2/11 at 5 P.M. The SSD indicated when residents have behaviors that endangers another resident (for example biting), the residents would be re-evaluated to see if there needs to be a change in their supervision status. She indicated this would have been reviewed/discussed at the IPOC (Interdisciplinary Plan of Care)			

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	meetings. After review of the clinical record, she indicated documentation was lacking of this review. She indicated documentation was lacking in the clinical record of a reassessment of the resident's supervision status/needs. The SSD was made aware at this time, the resident's clinical notes and the Behavior Detailed Entry Report did not reflect the same information regarding the resident's behaviors. The clinical record had more documented incidents of behaviors, that were to have been tracked on the Behavior Detailed Entry Report, and documentation of these behavior incidents were lacking on the Behavior Detailed Entry Report. On 4/28/11 at 1:16 P.M., the DON was interviewed. She indicated "close visual supervision" would be considered 1:1 supervision, as defined in the policy and procedure for Resident Supervision. She was made aware of the discrepancy of behaviors documented in the clinical record versus the lack of those documented on the Behavior Detail Report. She indicated staff utilize various tools to review behaviors at the DCR (daily clinical review) meetings including, but not limited to, nurses notes, physician orders and 24 hour report. She indicated the intervention put in to place after the resident ate the cigarette on 2/20/11 was			

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	she was placed on 72 hour charting. She indicated 72 hour charting indicates the nurses monitored her vital signs and monitored her for nausea and vomiting. The DON indicated the resident has continued on 1:1 supervision since her return to the facility on 3/11/11. The SSD (social service director) joined the interview at 1:20 P.M. She indicated she was unable to find documentation of the resident in her documentation and/or the IDT/DCR notes regarding the resident ingesting a cigarette on 2/20/11. B. The clinical record of Resident #100 was reviewed on 4/25/11 at 3 P.M. Diagnoses included but were not limited to the following: Dementia with behavior disturbances. The most recent MDS (minumum data set assessment) dated 1/17/11, included but was not limited to the following: total cognition score of 5, which indicated severe impairment; transfer and ambulation required extensive assistance (resident involved in activity, staff provided weight bearing support. The resident was admitted to the facility on 4/28/10. A fall/injury assessment: prevention and management plan of care had an initial date of 4/29/10. This form indicated the following fall/injury risk related to:			

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	unsteady, cardiovascular disease, bowel and bladder incontinence, dementia, antidepressant and sedative/hypnotic medications. This form indicated the resident had a history of falls on the following dates: 5/8/10 (2 falls), 5/15/10, 7/23/10, 8/28/10, 11/15/10 and 12/27/10. Interventions included, but were not limited to, the following: transfer required 1 or 2 assistance with gait belt; self release seat belt alarm; inservice CNA on staying with resident. Physician notification form, dated 11/30/10, indicated the following: "Resident has increase behaviors, non compliant with alarms..." Physician notification form, dated 12/13/10, indicated the following: "Resident has r (right) side weakness, r side of mouth drooping, fatigue..." Nurses notes, dated 12/13/10 at 1:30 P.M., indicated the following: "...slight drooping rt side of mouth noted, leans to rt slightly..." Nurses notes, dated 12/15/10 at 8 P.M., indicated the following: "...very non-compliant with SRBA (self release seat belt) on wheelchair. Many I (independent) transfer attempts made, staff assist."			

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	155368	A. BUILDING 00 B. WING	04/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TODD DICKEY NURSING AND REHABILITATION CENTER	712 WEST 2ND STREET LEAVENWORTH, IN47137

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Nurses notes, dated 12/26/10 at 2 A.M., "...res on 15 minute checks, up out of w/c in room, putting self to bed, alarm sounding, assisted x 1 staff person into bed..."

An accident/incident report, dated 12/27/10 at 6:45 P.M., indicated the following: "Rsd (resident) found on bathroom floor on buttocks. States she slid off commode...Bruise found to r (right) hand, 2 cm (centimeters) x 2 cm. Bruise to back of r leg..."

On 4/27/11 at 1:10 P.M., the DON provided a copy of the in service training on 12/27/10 provided to CNA #12. This form indicated CNA #12 was inserviced on Resident Safety with the objective: All residents with chair alarms cannot be left unattended on toilet.

On 4/29/11 at 9 A.M., the DON was interviewed. She indicated the resident had a self release seat belt in use at the time of the fall. She also indicated the resident should not have been left unattended on the toilet on 12/27/10.

3.1-45(a)(2)

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F0431 SS=D	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure proper medication refrigerator	F0431	It is the policy of Todd-Dickey Nursing and Rehabilitation Center to store all drugs and biologicals in locked compartments under	05/29/2011

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	temperatures were maintained between 36-46 degrees Fahrenheit for 1 of 4 refrigerators. The refrigerator included medications for the following residents # 1, 2, 3, 4, 5, 6, 7, 11, 12, 13, 15, 17, 18, 20, 22, 25, 26, 29, plus included house medications Findings include: On 4/26/11 at 10:35 A.M., an observation of the East Hall medication room refrigerator indicated the temperature was 29 degrees Fahrenheit. No medications were frozen. Each medication was checked individually. All medications were to be returned to pharmacy. Medications found include Resident # 1 had 10 Dulcolax suppositories `10 mg and levemir insulin, 1 unopened vial. Resident # 2 had 10 Dulcolax suppositories 10 mg. Resident # 3 had 12 acetaminophen suppositories 650 mg. Resident # 4 had 6 Dulcolax suppositories 10 mg and 1 vial of Lantus unopened. Resident # 5 had 7 Dulcolax suppositories 10 mg. Resident # 6 had 1 unopened vial of Lantus insulin. Resident # 7 had 12 phenergan 12.5 mg suppositories and 10 Dulcolax		proper temperature controls.1. All medications in noted refrigerator were either destroyed or sent back to pharmacy and replaced at facility expense.2. All other medication refrigerator temperatures were assessed and were found to be in compliance with the facility temperature policy.3. Nurses will be re-educated on facility policy for medication refrigerator temperature ranges as well as policy for checking and documenting temperatures and how to report abnormal temperatures. Education will be added to the facility's general orientation for newly hired nurses.The DON/designee will audit medication refrigerators three times weekly for appropriate temperatures and documentation. Maintenance will also perform a weekly audit of refrigerator temperatures to ensure equipment is working properly.4. The QA committee will review the results of these audits, monthly, for any corrections or updates as indicated. Any non-compliance will be addressed by the administrator/DON through 1:1 re-education and/or disciplinary action.	

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	suppositories 10 mg. Resident # 11 had 8 Dulcolax suppositories 10 mg. Resident # 12 had 8 Dulcolax suppositories and 12 acetaminophen suppositories 650 mg. Resident # 13 had 14 Dulcolax suppositories 10 mg. Resident # 15 had 9 Dulcolax suppositories 10 mg and 1 unopened vial of Lantus insulin. Resident # 17 had 8 Dulcolax suppositories 10 mg. Resident # 18 had 3 Dulcolax suppositories 10 mg. Resident # 20 had 4 Dulcolax suppositories 10 mg. Resident # 22 had 5 Dulcolax suppositories 10 mg. Resident # 25 had 1 unopened vial of Novolin N 70/30 insulin. Resident # 26 had 9 Dulcolax suppositories 10 mg. Resident # 29 had 24 acetaminophen suppositories 650 mg. House supply included 10 - 3 ml hepatitis injection syringes. On 4/26/11 at 11:00 A.M., a review of the Refrigeration Temperature Log indicated the temperature was 30 degrees Fahrenheit for the "A.M. reading of the log" for April, 2011. The log documentation indicated the following			

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	days with temperatures below 36 degrees Fahrenheit (F): April 14 A.M. = 30 degrees F. April 15 A.M. = 30 degrees F. April 22 A.M. = 30 degrees F. April 24 A.M. = 32 degrees F. April 25 A.M. = 32 degrees F. April 26 A.M. = 30 degrees F. On 4/26/11 at 11:30 A.M., an interview with the Director of Nursing indicated the medications would be returned to pharmacy and replaced due to low temperatures on previous days. On 4/26/11 at 1:10 P.M., a review of the policy and procedure for Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles indicated at number 11 that "Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges." The ranges indicated, "Refrigeration: 36 to 46 degrees Fahrenheit." 3.1-25(m)			